Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Texas Health HEB

Respondent Name
New Hampshire Insurance Co

MFDR Tracking Number
M4-14-2685-01

Carrier's Austin Representative
Box Number 19

MFDR Date Received
April 28, 2014

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "HRA has been hired by Texas Health HEB to audit their Workers Compensation claims. We4 have found in this audit they have not paid what we determine is the correct allowable per the APC allowable per the new fee schedule that started 3/01/2008…"

Amount in Dispute: $76.16

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: Written acknowledgement of medical fee dispute was received however, no position statement was submitted.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
August 30, 2013	Outpatient Hospital Services	$76.16	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the fee guidelines for outpatient acute care hospital services.
3. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional medical services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 97 - the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - 18 – Duplicate claim/service

Issues

1. What is the applicable rule for determining reimbursement for the disputed services?
2. What is the recommended payment amount for the services in dispute?
3. Is the requestor entitled to reimbursement?

Findings

1. The Division placed a copy of the Medical Fee Dispute Resolution request in the insurance carrier's Austin representative box, which was acknowledged, received on May 6, 2014. The insurance carrier did not submit a response for consideration in this review. Per the Division's former rule at 28 Texas Administrative Code §133.307(d)(1), effective May 25, 2008, 33 *Texas Register* 3954, "If the Division does not receive the response information within 14 calendar days of the dispute notification, then the Division may base its decision on the available information." Accordingly, this decision is based on the available information.
2. 28 Texas Administrative Code §134.403(d) states in pertinent part, "For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided…" Review of the submitted medical bill finds:
   - Per Medicare policy, "Standards of medical / surgical practice} procedure code 96374 should not be reported with codes for which IV push or infusion is an integral part of the procedure. No documentation of significant separately identifiable evaluation and management service was found. Separate payment is not recommended.
3. The total allowable reimbursement for the services in dispute is $0.00. No additional reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		July , 2014
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.